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ABSTRACT

Intended for use as part of an inservice program, this guide was designed to provide insight into adolescent suicide and to serve as a reference tool. It begins with an overview of suicide, citing society's desensitization to death, rapid changes in society, success codes, and the disappearance of the extended family as factors in the increase of adolescent suicides. Suicidal signs and symptoms are explored in the next section and several high-risk student behaviors are listed: depression, school problems, substance abuse, radical change in lifestyle or behavior, sudden happiness, uncharacteristic promiscuity, verbal threats, death themes in student's art, music, etc., previous suicide attempts, unusual purchases, and giving away possessions. The analogy of a trip is made to help educators gain information from a potentially suicidal student. Several suggestions for dealing with suicidal adolescents are given. A philosophical reason for suicide is included and the thought processes involved are listed. Prevention and intervention are addressed and charts are included to illustrate plans of action. Suggestions are also given for what to do and how to respond when a student's suicide attempt is successful. The need for educators to take care of themselves and their feelings when working with suicidal students is emphasized. References are included. (NB)

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Adolescent Suicide

An Educators Guide

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April, 1987

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FOREWORD

Stopping Self-Destruction . . . An Educator's Guide, is written with the aspiration that the use of the ideas discussed will help alleviate the overwhelming pain of students in crisis, as well as provide avenues of prevention and support for staff members.

Intended for use as part of an inservice program, this guide was designed to provide insight into adolescent suicide and serve as a useful reference tool. Additionally, it can serve as a springboard for mutual sharing among inservice participants. Suicide can be a very emotionally charged issued. Providing a time for education concerning the "truths" of the subject, as well as dealing with fears, anxieties, and other emotions staff members may feel is, in my opinion, **mandatory.**

This guide would not have been a reality had my life not been touched repeatedly by those in overwhelming pain. To those people, this guide is dedicated.

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AN OVERVIEW OF SUICIDE

Depending upon the source quoted, suicide is considered the primary to the tertiary cause of death in adolescents, aged 15-19. The National Center of Health Statistics lists suicide second only to accidents. However, many of the reported "accidents" are actually *successful suicide attempts*; such erroneous classification mitigates the awareness/serious of the teenage suicide problem. An example of this misreporting is the single car "accident" death, especially when there is no evidence of brake marks. Pre-adolescent suicidal deaths are frequently misclassified as "accidents" due to the nature of the young person's chosen method of self-destruction. Such methods include (but are not limited to): setting himself on fire; hurling himself down stairs or out of a window; choking himself to death.

It is estimated that 5,000 deaths per year are attributed to adolescent suicide. For each completed act, there may have been 50-60 unsuccessful attempts. *Each day*, an estimated 57 adolescents attempt suicide, and 13 complete the act. Fifty percent of those who *complete* suicide had a history of previous attempts. Ten percent of those attempting suicide will try again within the year.

Female attempters greatly out number males; however, males have a much higher completion rate. The method of preference is overdosing with drugs.

Adolescent suicide has increased 400% in the last 20 years. Some reasons expressed for this increase include:

Society's Desensitization To Death
Examples include readily available themes of violence and death on VCR tapes, at the theatre, and even in cartoons. Many times these shows make no value judgements and a "Why Not?" attitude develops.

Rapid Changes in Society
Technological advances, losses of a way of life (farms dissolving), foreign concerns (Russia, Libya, Iran), etc.

Success Codes
Includes "Yuppyism", "Microwave Happiness", advertising implying everyone is married, employed, and has two children, a boy and girl. (Only 17% of U.S. families fit this concept).

Disappearance of the Extended Family

Feeling *wanted, loved,* and *needed* are basic human desires. In the not too distance past, if the nuclear family was remiss in any of these areas, extended family members "took up the slack." Today, however, grandparents are placed in nursing care facilities, and nuclear families are moving with frequency that would rival the military to satisfy impersonal corporate business requirements. The *typical* home life of a suicidal adolescent inlcludes some or all of the following:

- Divorce or death of a parent
- Family history of alcoholism
- Family history of depression, especially maternal suicidal tendencies
- Parental emotional neglect
- Poor relationship with father

Depression seems to be a common theme among suicidal adolescents. Depression can be expressed through sexual promiscuity, school failures, and atypical sleeping and eating patterns. Physical illness may also be an expression of depression, with 50% of adolescents having seen a physician within a month of their attempt, and 25% within a week.

SUICIDAL SIGNS AND SYMPTOMS

Awareness and *sensitivity* should be the watchwords for those who deal with students. Educators must become familiarized with the potential warning signs and tuned in to the specific problems of the teenagers.

A large percentage of those contemplating a suicide attempt send out *"Whispers for Help"*. These include statements such as "I want to die", "It isn't worth it," or "It's hopeless." Other signs include a radical change in lifestyle, such as not showing interest in hobbies, keeping an emotional distance, giving away priced possessions, using drugs, and collecting firearms, razor blades, pills, etc.

"Suicide Gestures" are identified as an experimentation with death. Gestures include suicidal attempts of low lethality. These may include aspirin overdoses, wrist slashes, or mild drug overdoses. These are a way of expressing the need to be relieved of agonizing pain.

A **"Cry For Help"** is what the actual attempt is commonly called. *All* suicide attempts should be taken seriously. Students attempting suicide don't want to die, but to escape PAIN. Those surviving talk not about death, but the overwhelming desire to escape their seemingly unbearable pain. What they don't realize is that successful suicide is a permanent solution to what is, in all probability, a temporary problem.

Behaviors students at high risk for suicide may exhibit:

Signs of Depression
Changes in eating and sleeping habits
Feeling of hopelessness and guilt
Loss of interest in usual activities

Problems in School
Dramatic drop in grades
Behavior *uncharacteristic* of a student

Substance Abuse
The student sees this as a way to block the overwhelming pain.

Radical Change in Lifestyle and/or Behavior
A student may show no interest in a favorite hobby, a usually neat person may become unkept, a normally friendly person may maintain an emotional distance.

Sudden, unexpected happiness
Following a prolonged depression, unexpected happiness may indicate the person is no longer wrestling with decision making. He/she has found the solution through a conscious decision to kill himself/herself.

Promiscuity (if change from normal)

Verbal Threats
May include such statements as, "No one needs me", "You won't see me around anymore", "You're going to regret how you treated me", "I can't go on", etc.

Death Themes
These can be exhibited in the student's art, music, poetry, etc.

Previous Suicide attempt

Unusual Purchases
These may include talk of hoarding medicine, acquiring rope, knives, guns, or razor blades.

Giving Away Prize Possessions
This indicates that the suicide attempt is imminent. Usually done after the decision to kill himself/herself has been made.

THE POTENTIALLY SUICIDAL STUDENT AND YOU

When working with a student expressing suicidal ideation, it may be helpful to think of your information gathering likened to that of a trip. Suicidal tendencies exist on a continum, from an absolute wish to live, to an absolute wish to die. Information related to "travel", the odyssey of self-destruction, will include many details. To help you remember key statements, the analogy of a trip may help.

TRIP ANALOGY

Your Thought Stimulus

Travel Plan?
1. How badly do you want to go?
2. Who or what will you miss?
3. How long have you been planning the trip?

Statements Actually Pursued

1. Do you have a method?
2. Is a suicide date set?
3. Will you miss anyone or thing?
   (may give clues to positive support person or reason to postpone attempt)
4. Length of plans will provide insight to time of suffering, past attempts, etc.

The more specific the details of the trip, the more imminent the suicide attempt.

Additional information that will be helpful in assessing the student's immediate suicidal intentions include finding out:

1. What has happened to make life not worth living?
2. How often and how long have the suicidal thoughts been occurring?
3. On a scale of 1-10, what is the probability of attempting suicide?
4. How badly does the student want to live or die?
5. Is there anyone or anything stopping the student from killing hemself/herself.
6. Any previous suicide attempts?
7. Is there a plan?

Generally speaking, a student at **greatest risk** for suicide include one who is giving away prized possessions; sudden, **unexpected** happiness following prolonged depression; making unusual purchases, such as a rope, knife, gun, etc. and having made a previous suicide attempt, particularly if the attempt has been within a year.

Suggestions for Dealing with the Suicidal Adolescents:

Listen
Use "Active listening" techniques to the best of your ability

Be Affirmative and Supportive
A strong, stable role model is essential

Evaluate the Seriousness
Use as a guide the behaviors discussed previously

Evaluate the Intensity
Is there a "plan"? Does the student seem to have a single minded purpose in his attempt?

Take All Threats Seriously

Ask the Student Directly If He/she Wants to Kill Himself/Herself
Use the word "Suicide", or ask the student **directly** if he is thinking of killing himself. This relieves the student, knowing he can now discuss his dilema, instead of keeping the "secret." A student will also be quick to tell you if he is not thinking of suicide.

Evaluate Positive Resources Available to Student
These may include parent(s), other relatives, guidance counselor, clergy, etc.

Be Specific, Do Something Tangible
Depending on the perceived needs of the student, this may include contacting a helping person, arranging a date, time, and place to see the student again, etc.

Don't Handle Problem Alone
Make the appropriate referral, if indicated.

No Secrets
A student may express a desire to share with you, but only if you "promise not to tell." Do not make any promises! Let the student know you are available to talk, and will do everything in your power to help him. Once the "secret" is shared, a student is usually adamant about

not notifying parents. This concern needs to be discussed, the fears alleviated, and the call to parents conducted in the presence of the student, whenever possible. Friends of the student expressing suicidal ideation who may want to share their "secret" with you must be alerted that this secret is one that is too big to keep, and in doing so, may lead to the death of a friend.

If, after a discussion with the student, it is felt there is a danger of a suicide attempt, appropriate referrals need to be made. A "Rule of Thumb" is to spread the concern to others. The principal, vice principal, and guidance counselor are examples of key people who need to be apprised of the situation. Your school's plan of action for suicide ideation may, however, suggest other referrals.

PHILOSOPHIC FOOD FOR THOUGHT

Stekel's ancient "Law of Talion" has been cited as one of the philosophical reasons for suicide. This "eye for an eye" theory manifests itself in suicide using the following thought processes:

1. A person wishes another were dead.
2. The wish, because of societal norms, can not be manifestly expressed.
3. This murderous wish is a "crime" (in thought) and the wisher must be punished with a penalty fitting crime.
4. The person feels guilty for conceiving the wish.
5. Guilt can only be expunged through his own death (eye for an eye) and self-inflicted. In effect, the child is symbolically killing the parent(s). Another expression used for this phenomena is "Inverted Homicide." Indeed, Menninger wrote in "Man Against Himself" that suicide was . . . displaced murder." The suicidal person may have a specific person in mind to be the "victim." Suicide has also been termed the ultimate obedience to parents. This situation is found when the child feels unwanted and unneeded. To "solve" the problem, the child kills himself to get permanently out of the way of the parent and their pursuits.

PREVENTION AND INTERVENTION

Prevention and **Intervention** are the watch words of public education in today's culture of legal suits, limited nuclear and single parent families, and throwaway children. Regardless of their philosphic thought, schools are ever increasingly taking on more of a parental role, which includes being on guard in identifying potentially suicidal students.

Prevention and intervention begin with staff awareness. **All staff,** including bus drivers, cafeteria and janitorial workers, as well as the professional staff, should be afforded an opportunity to receive training about depression and suicide. It can not be emphasized too strongly that not all staff members will be comfortable dealing with this topic and may not wish to participate. Every 2 or 3 years, updated information should be made available to keep the staff's knowledge current. New staff members should receive training as part of their orientation.

Team Approach

An effective method of providing appropriate assistance to students in need is the formation of a school based Intervention Team. The chosen name, such as the "Adoloscent Study Team" or "Crisis Intervention Team" is not as critical as its functions. Team members may include a building administrator, counselor, nurse, and psychologist. Monthly meetings would focus on written referrals, submitted by staff members during the preceding week, identifying students who exhibit behaviors that may categorize them to be at risk for self-destruction. A plan for dealing with these students might range from a student having weekly meetings with a trusted "significant other" who is a staff member, to contacting parents, insisting on immediate intervention by a trained mental health professional. Students names would appear on the monthly discussion list until acceptable behavior is achieved. A confidential record would be kept by a team member of those students discussed.

An excellent public relations tool would be a booklet or phamplet explaining the purpose of the team.

Contents may include:

- Defining the resource team.
- School model for dealing with a crisis.
- Useful information for staff and parents on such topics as divorce
- and other losses, depression, and suicide.
- Bibliography.

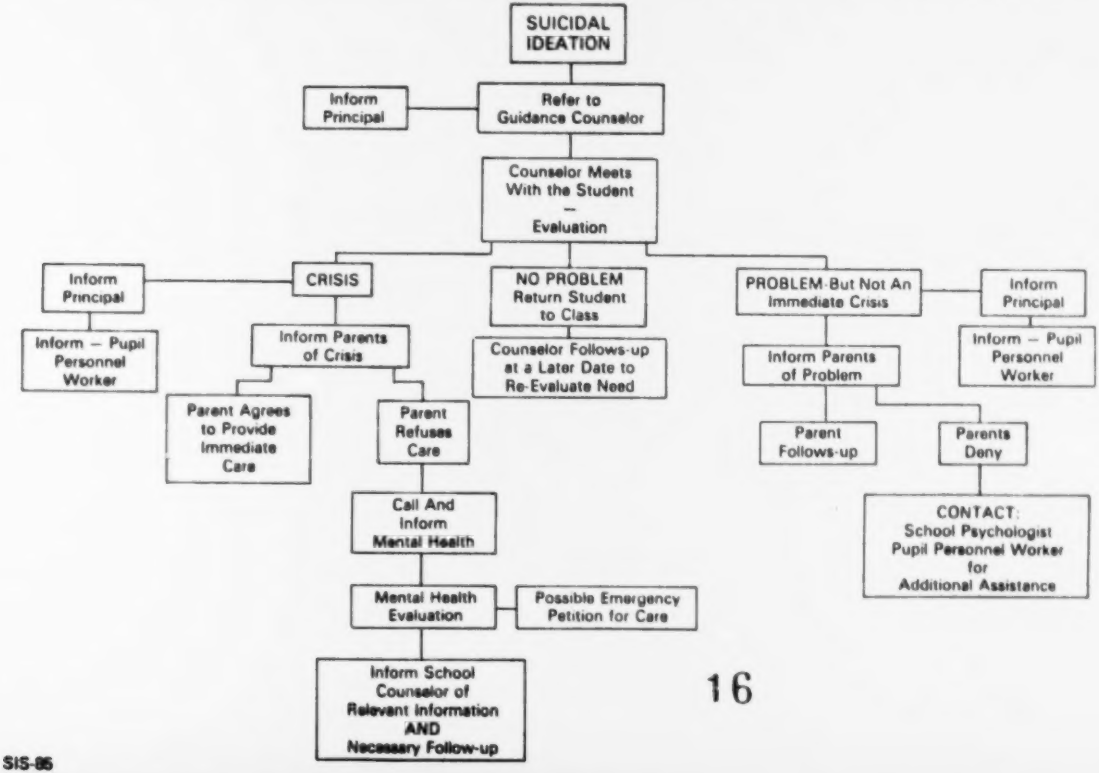
Parent and Student Programs
A well planned public lecture series, seminars, and workshops on topics such as suicide and grief would serve as excellent public relations tools. Students would be provided information on the topic of suicide through health classes, the student handbook, and well trained peer helpers. (Please note I'm referring to peer helpers as providers of information, not counselors).

Guidelines and procedures also need to be in place for a student who expresses suicidal ideations that are brought to the attention of an educator. The following Suicidal Ideation Charts address that issue, with a referral system that has been in successful use for several years in Washington County, Maryland school system. Alterations could be made to tailor its use to your particular district.

GUIDELINES AND PROCEDURES FOR STUDENT

Suicidal Ideation

Personnel should follow the proposed referral system when dealing with a student when we are aware of suicidal ideation.


SUICIDAL IDEATION
Refer to Guidance Counselor
Inform Principal
Counselor Meets With the Student – Evaluation
CRISIS
Inform Principal
Inform – Pupil Personnel Worker
Inform Parents of Crisis
Parent Agrees to Provide Immediate Care
Parent Refuses Care
Call And Inform Mental Health
Mental Health Evaluation
Possible Emergency Petition for Care
Inform School Counselor of Relevant Information AND Necessary Follow-up
NO PROBLEM Return Student to Class
Counselor Follows-up at a Later Date to Re-Evaluate Need
PROBLEM-But Not An Immediate Crisis
Inform Principal
Inform – Pupil Personnel Worker
Inform Parents of Problem
Parent Follows-up
Parents Deny
CONTACT: School Psychologist Pupil Personnel Worker for Additional Assistance

SIS-85

PLAN A — CRISIS

1. When school personnel become aware of suicidal ideation in a student, that person will immediately refer the student to the guidance counselor.

2. Counselor will notify the principal. Principal notifies pupil personnel worker.

3. Counselor evaluates the student and determines if a serious situation exists.

4. If further action is necessary, the counselor will notify the parents and inform them of the crisis and ask if they prefer to seek help for the student privately or for the counselor to call the Health Department (791-3220) for emergency services. (If unable to contact the Mental Health Departmemt call the Emergency Services, Washington County Hospital – 824-8300).

PLAN B — NOT AN IMMEDIATE CRISIS BUT NEEDS INTERVENTION

1. Referral.

2. The counselor after meeting with the student determines a serious problem is evident, but the student is not in need of emergency care, the counselor will inform the parent of the problem and request they seek additional help.

3. If the parent denies a problem, the counselor will involve the school psychologist, pupil personnel worker, or other personnel as needed to pursue further intervention.

5. If parents deny a problem and choose not to plan for immediate care for the student, the counselor will notify the Washington County Mental Health Department and request an evaluation as to the seriousness of the student threat.

6. Emergency personnel from the Mental Health Department will, if necessary, see the student that day either at the school or the Mental Health Clinic.

7. After a student intervention, the Mental Health Department personnel will communicate with the school counselor to discuss relevant information and any necessary "school plan(s)." The school counselor will contact other school resources as necessary (psychologists, pupil personnel worker, nurse, and other school personnel).

8. If parent has chosen private professional assistance, the counselor, pupil personnel worker, psychologist, or principal should contact the parent and request any information relevant to school planning.

- The principal may choose to document the parental contacts with a brief letter to the parent.

- At any step in the process the counselor may contact the school's psychologist, pupil personnel worker or board staff personnel for additional assistance.

WHEN TRAGEDY OCCURS

Even with the best proactive intervention, tragedy can occur. The student's successful completion of suicide does not warrant the dissolution of any intevention program already in place. It is very difficult to ascertain the number of lives **saved** through such efforts.

Those touched by suicide may experience tremendous conflict about why the victim ended his life. This conflict may touch the lives of any number of students and staff, regardless of how well they knew the victim. Frequently, there is guilt and anger, usually from a perceived failure to prevent the suicide.

Shock, disbelief, stigma, and a sense of rejection compounds the natural grieving process. The bereaved may experience depression, illness, accidents, excessive drug use, or thoughts of suicide themselves to end the seemingly unbearable pain.

A large majority of adolescent suicides occurs on weekends or weekdays between the hours of 3:00 p.m. and midnight. If the suicide has taken place in this time frame, and the administration is alerted, the principal may have time to notify the staff of a speical early morning meeting to outline the plan of action for the day. **Hopefully, a plan has previously been developed,** with school staff already aware of the method of implementation. Suggestions for dealing with the tragedy include:

- Extension of the homeroom period, allowing time for teachers to provide known facts to students, in hopes of dispelling rumors. Teachers may also want to discuss such feelings as shock, disbelief, and anger.

- Establishment of a "crisis center", preferably in the guidance area, where students and staff may go for support. Arrangements may be made for an "outside expert", such as a psychiatrist or other mental health professional to assist in the center.

- A large school assembly, led by a competent mental health professional, can be crucial in helping students deal with their feelings of shock, disbelief, anger, and guilt.

- Student involvement in planning a memorial service and/or fund, encouragement in writing poetry and essays, or in keeping journals all help in an expression of feelings.

- Teachers can encourge students to express their feelings, both positive and negative ones. Students should also be made aware that such physical reactions as headaches and upset stomachs are common and **natural** responses to grief.

  With the rapid increase of "cluster suicides" (i.e., groups of students attempting and/or completing suicide), an intervention plan is of the utmost necessity for preventing the needless destruction of our young people.

IMPORTANT THOUGHTS FOR YOU!

Dealing with suicide is an emotionally wrenching experience. It takes great courage and determination to maintain the emotional state of calmness and confidence when confronted by a student in crisis. These crisis situations usually occur at the most inopportune times, when we are least expecting it. Yet, it is important that we maintain a composed, stable, outward appearance. In doing this, we many times bottle up our own personal emotions. The impact of suicide can haunt a person for a long period of time. For these reasons, it is **imperative** that those dealing with suicide seek out a trusted friend, colleague, or counseling professional to discuss with them the many emotional anxieties that need to be examined and laid to rest. It is also beneficial to take very good care of yourself at this time. It is exceedingly difficult to care for others in an effective way if we, ourselves, are hurting physically, mentally, and/or emotionally. Adequate diet, rest, and exercise, in addition to small "treats" we may pamper ourselves with, are very important when a crisis enters our lives.

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